Kaufman Independent School District

Parent/Physician Request for Administration of Medication by School Personnel of NON-prescription medication administered for LESS than 10 (ten) consecutive days.

Date of Request:_____ School:_____ Grade/Teacher: ___/_____

Student's Name:_____ Birth date: _____/_____/_____

Medication:_____ Exp. Date _____ Dosage:_____

Fax Number:_____ Phone Number: _____

*****Medication MUST be in Original Container*****

Method of administration: ( ) by mouth ( ) inhaled ( ) topical ( ) eye(s) ( ) ear(s) ( ) nasal ( ) gastric tube

Time to be Administered:_____ Dates to be Administered:_____

Condition for which medication is required: _____

Has your child ever taken this medication before? ( ) YES ( ) NO

Medication Allergies: ( ) No **KNOWN** Medication Allergies ( ) **Allergic to**: _____

Special Instructions/Precautions/Side Effects of medication on your child: _____

_____

Physician's Name:_____ **Physician's Signature:**_____

Physician's Phone #:_____ Physician's Fax #:_____

My signature below indicates that I request that KISD staff administer the medication specified above to my child, and I am giving permission for KISD staff to contact the physician for additional information, if needed.

Parent/Guardian Signature:_____ Email:_____

Parent's Daytime Phone:_____ x_____ Cell Phone:_____

FOR OFFICE USE ONLY!

Medication Count: ☐ Entered

Date	# Pills	Counter's Signature	Witness Initials	Date	# Pills	Counter's Signature	Witness Initials

Comments (Indicated by * on back of form):

Date	Comments	Date	Comments

Date	RN Review

Medication Returned to Parent/Student: _____ Date: _____